TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Marcus Hayes, D.C.

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-14-3107-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… the DD addressed MMI (with subsequent IR determination) and extent of injury determination. Therefore, both were addressed as the treating doctor was in disagreement with the DD's findings of MMI/IR and extent of injury. Therefore, the billing codes submitted reflected the issues addressed by the DD as per sections 408.0041 (f-2) and 408.0041."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 13, 2014	Referral Doctor Examination to Determine Extent of Injury	$500.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 296 – Service exceeds maximum reimbursement guidelines.
   - W1 – Workers compensation state fee schedule adjustment.

- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code W1 – "WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT." 28 Texas Administrative Code §134.204 (k) states, in relevant part,

> The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a **Division or insurance carrier requested** [emphasis added] RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE" …

Review of the submitted information finds that the documentation does not support that the disputed service was requested by the Division or the insurance carrier. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	October 9, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.